Nursing Facility Transitions Policy and Procedure Workgroup Minutes

January 7, 2008, 1pm to 5 (Comfort Inn) Bismarck
January 8, 2008 9 am to Noon (Pioneer Room, State Capitol)

Documents Provided/Reviewed: Nursing Facility Transition Process, Draft Informed Consent for Participation, Role Matrix, Draft Transition Assessment, Draft Independent Living Plan, HCBS Notice of Reduction, Denial, or Termination, Section B of the MFP Operational Protocol requirements

Workgroup Members Present: Judie Lee, IPAT, Sandy Arends, SEHSC Aging Services, Gwen Beckler, Dakota Center for Independent Living, Bruce Murry, ND P &A, Sharon Klein, Missouri Slope Lutheran Care Center, Meredith Baumann Valley Eldercare Center, MAryDein, Dakota Central Social Services District, Diane Mortenson, Stark County Social Services, Royce Schultze, Dakota Center for Independent Living, Susan Ogurek, Independence Inc, LaRae Gustafson, Options CIL, Stephen REpnow, Independence Inc, Helen Funk, DHS Ombudsman, Colette Mund, Burleigh County Social Services, Jodie Fetsch, RN Custer Health, Rhonda Heartfield Bismarck Senior Center, Randy Sorensen, Options CIL, De'Ette Ruggels, Pat Danielson, Jake Reuter, MFP Grant Manger, DHS, Medical Services

1. Introductions of participants was completed along with a review of the documents provided for the meeting
2. Eligibility criteria change recommendations made by the Goals and Benchmarks Workgroup was reviewed with the group. The eligibility criteria outlined in the grant proposal was reviewed along with the finding that when this criteria was applied to a recent MDS data probe most potential eligible candidates were disqualified. The recommendation that all individuals with a preference to return to community living be referred the transitional coordinator and the nursing home social worker for review and discussion was outlined.
3. Discussion related to this recommendation resulted in the decision that all individuals referred for transitional coordination services will be dually referred to both the Transitional Coordinator and the Nursing Facility Social Worker for review.
   The next step in the process would involve the Transitional Coordinator and the Social Worker meeting with the individual that has been referred to discuss their interest in participating in the MFP Grant Demonstration Service.

   Family members would be involved in this meeting as the nursing home resident/consumer wishes.

The transitional coordinator and the social worker would discuss the service needs and options to the extent possible so that the individual can make a decision about participating in the Grant/Transitional Coordination service

4. It was agreed that the Transitional Coordinator will need to educate the Nursing Home Social Workers/nursing home staff to provide information about the MFP transition coordination demonstration service
5. If the individual wishes to participate in Transitional Coordination Services the TC will have the MFP consent document signed, secure an authorization to disclose information (ROI) to exchange information with the nursing home, County Social Services
   MFP and CIL information will be provided-appeals, program brochures etc….
   Nursing Facility Transition Referral document will be completed by the TC with copies provided to the consumer, NF SW, and the MFP Grant Manager
6. The consumer will be provided with a copy of all the documents
7. County Social Services Office will be contacted related to Medicaid eligibility questions/issues that maybe identified
8. Contact with HCBS case manager will be initiated at any time in the process with questions about available services. The HCBS Case Manager will be invited to participate in the transition planning process/the development of the Independent Living plan when it appears that a transition appears realistic
9. Need to remember that we are developing a process for transition that will meet the needs now for MFP participant and in the long term for persons that need assistance or that wish to remain in the community

10. The Transitional Coordinator will complete an assessment for the purpose of indentifying support/service needs

11. The SAMS system will be used to develop the transitional assessment so that it the results/information will be transferable to the HCBS/OAA assessment

12. Transition Assessment Issues identified

    - Does the SAMS system allow the HCBS Case manager to have access to Transition assessment information
    - Concern noted about the use of SAMS because of the proprietary requirements of the System
    - Nursing Home staff will need to be consulted as part of the process to assure the best and most accurate information is included in the assessment

- Assessment copy needs to be provided to the Nursing Facility
- Training manual will need to be developed and all TC staff trained to assure the assessment is completed consistently
- All sections of the assessment will not need to be completed by the TC and some section will only be completed later in the transition process-Assistive tech, household items needed etc….
- Section one-no changes made
- Section two-no changes made
- Cognition questions need to be more specific and address medication that maybe used to address dementia-Do we use Mini Mental Exam
- Emotional Well being section need some review-Question B-5 would be better if it had a 1-5 rating instead of a yes or no answer and need to expand question B-6, B-14-made negative statements (about self)
- ADL/IADL sections will remain the same
- Section 4.C was questioned related to its adequacy
- Section 5-No changes –to be used by HCBS Case Manager
- Section 6-No changes
- Section 7-New section with additions that will need to be created
- IPAT Assistive Technology section could be added as a separate section

13. Assistive technology assessment needs to be completed during the transitioning process
14. IPAT has developed an assessment that could be built into the transition assessment (to be completed as the transition/discharge team deems most appropriate
15. Good AT can decrease the level of need for QSP assistance-environmental controls is one example
16. IPAT could provide education to Social Worker/Nursing Home staff related to AT with the Long Term Care Convention or during the Social Work fall conference-Regional SW meetings will also be an option for education
17. IPAT has a loan program available to assist with the purchase of AT (AFLP)
18. MFP supplemental services can pay for AT
19. IPAT staff could do consultation by speaker phone or video conferencing
20. IPAT has an equipment loan library and a swap shop to assist with the use of reuse of equipment
21. Cross County Carrier will transport equipment for free for IPAT
22. Diversion Activities/Planning will be needed to better serve individuals such as person in a hospital. Discharge planners will need to have additional education and resources to optimize the options of returning to live in the community

23. No MFP Assistance for transition assistance for persons that have lived in a nursing home for less than 6 months is identified as a barrier
24. The CILs can provide assistance for any person that has lived in the NF for less than 6 months
25. Family Opposition to transition will occur at times-Guardians will at times act in ways that may not be in the best interest of their ward. Referrals to P & A, Ombudsman staff, or Legal action may be needed in some cases
26. Socialization after transition will be critical for success and will need to be addressed in the assessment
27. Psychosocial aspects will need to be assessed.
28. CILs offer a peer visiting program
29. Rural areas have little transportation which makes things more difficult to get to activities
30. Rural areas tend to have less things to do such as cafes, bars, senior centers
31. When individuals are alone they will sometimes get lonely and call staff. "CIL staff are not social visitors"
32. Important to give individuals opportunities and tools to use to handle their leisure time
33. Some people prefer to be alone and this needs to be noted
34. Senior companion can be used
35. Recreation therapist maybe able to assist with the types of questions to include in the transition assessment-What does the person like to do?
36. Housing options can assist in dealing with leisure issues-Senior Housing complex has social activities available
37. Toileting is common issue for admission to the nursing home and in serving persons well in the community
38. Question was raised about why seniors do not get the same treatment as a younger person-usually do are provided with fewer options.
39. Education is need related to options/choices for incontinence care needs-catheterization
40. Concerns about how the Health department handles catheterization in the nursing home-need for education related to use of catheterization for someone moving to the community
41. Concerns about people having to deal with urine odor and potential ostracized was discussed
42. Need to protect choice for persons transitioning-Risk needs to be assessed and mitigated but not at the expense of a individual's right to choose or make bad choices

January 8, 2008 Meeting

Nursing Facility Nursing Transition Process

- Case Managers asked if a family member could be present at an assessment to get true picture of condition of person.
- Could use a number of tools including review of the chart, talking with staff that works with the individual etc.
- The assessment at the nursing facility would be at a scheduled time to allow for important people to the case being able to be present.
- How do we look at the emotional questions on the MDS? Part of the training of social workers is to look at the cause of depression. Is it situational or chemical, etc. Subsequent questions help really define the real reason for the emotional status.
- Question about B5. It seemed like an odd question. It was geared to see what the energy and interest level was of the person
- Every question allows for the narrative portion to further describe the exact situation.
- The assessment has taken into account a variety of depression assessment tools.
- The emotional well being is a required section.
- B 14 was discussed. Again, it will take assessment skills to filter out if this is truly depression or just a personality or generational characteristic.
- The product you get from the assessment truly depends on the skill level of the assessor. We need to come to an agreement on the tool and then trust the professionalism of the assessor.
- Is there a spot on the assessment to talk about the social aspect that will occur when an individual goes home and does not have all the people around them? **It is currently on page 13, but should be expanded upon.**

How does the group feel about the assessment process that was described yesterday? There were no additional comments or suggestions at this time.

It will be important to keep data on the individuals that go through the assessment and then choose NOT to move. This will be important for data collection.

Referrals should be passed on to Jake if receiving referrals from individuals that meet the criteria for transition.

How do we want this transition process to work after the MFP grant is done? This is information that can be utilized on an ongoing basis.

Do we build the Assistive Technology needs right into the assessment or have a separate portion? IPAT has a form that could be tweaked to do that assessment for the MFP transition process. Randy noted that he thinks the current assessment raises all the appropriate questions for the group and takes a broader look at what accommodations the individual needs.

It's hard to consider what's available in the Assistive Technology world unless they are aware of what is currently available because that area is always changing and new technology is an ongoing opportunity. When do we engage the questions about what is available for the person to be able to live in their own home.

Randy thinks that as soon as possible after the assessment, we need to bring in the appropriate people.

Randy thought there should be more questions in the Nursing Facility Transition referral sheet that includes what led up to the admission, what kinds of things caused them to go into the nursing home, what couldn't they do, what issues occurred with laundry, cooking, taking meds, etc. OT in the nursing home generally reviews some of these questions. Most nursing facilities have full time OT or contract with them.

Jake asked for input on the role matrix.

Independent Living Plan:

Leah Rae said the centers are mandated to have certain categories of goals.

This is what the centers currently use. Do we want to continue to call it this? The transition coordinator is also expected to complete a plan for ongoing success and review I the community.

Randy noted that these topics in the plan are used for the reporting mechanism to the federal government as related to the CIL's.

Jake expanded on what is required for reporting within the MFP grant.

Leah Rae noted that some of the categories will encompass several of the topics reviewed in the assessment.

Health and safety go under the self care in the current CIL assessment.

Jake noted that on the Ohio document, several categories will fit under self care.

Le Rae noted that the CIL's perspective is to thoroughly involve the client to be directing their plan. From the nursing facility perspective, they also advocate for self determination of the resident. Both entities should be able b working on the same page. Meredith noted they have learned helplessness after being in the NF. They must be able to be managing their needs with accommodations to be independent versus relying on staff/others to do their consumer responsibility. This needs to be stressed from the outset.

"I want to make up my own mind about what I want you to do for me."

It will probably take several meetings throughout the transition time to accomplish the transition planning with the consumer at the center of the plan.

Any concerns about the categories of the plan? The interventions or approaches are written under each goal. One suggestion was to have more space, one page each for each category.

We could change the format from horizontal to vertical to allow for more space on sheet for goal, action plans, etc.

The resident care plan in the nursing facilities may need to be changed to accommodate the standards needed in the nursing facilities.

The transition plan should be kept somewhere on the nursing facility chart, possibly in the social services section of the resident chart.

The team should decide where to put the separate categories of services depending on the individual.

Crisis prevention section should be changed to risk mitigation.

Sharon asked if they have someone that they as a nursing facility see as a good fit for MFP, who they should contact. They would refer directly to the CIL's If they have not been there for 6 months, they cannot access, MFP, but if they have been, they would probably quality for MFP.

Randy offered that they already could provide gaps in the service system that they are seeing. Would we be able to use that information for reporting to CMS? Absolutely, we would include that for CMS review. We can talk about how exactly we can capture that information.

Sharon noted that the 6 month guideline may be a barrier because by 6 months, they have usually settled in. We should keep track of these situations. Bruce noted that if they cannot move home because of legal issues, P & A would want to know.

How could we avoid the 6 month issue for the apartment to be kept? Some nursing facilities regularly send the letter out to hold the apartment for 6 months. Some NF's do not do this. Sometimes the apartment is gone before 6 months; people are placed in the nursing facilities prematurely.

Meredith will send a copy of the letter they use to send to the physician to say will be home in 6 months, SSI, it is 3 months and it goes to the county eligibility worker to continue holding the apartment for 6 months. It is very rare for the physicians to not sign this form. This would be a good tool to educate and train the other NF social workers.

We will add action steps to the form.

The state has estimate $2000 for supplemental services. This looks like it may be low. How do we want to manage that process? Minnesota has a $3000 limit. The amount is broken down into limits within that amount, for instance a $300 cap on pots and pans etc. Should we set a ceiling with the opportunity for exceptions?

Bruce: Each one will have to be approved separately. What is we kept it looser than an amount and have standards instead? The documentation would have to support the need. Could request that the transition coordinator provide documentation of why we would need more for one particular situation.

Discussion was held about reusing pieces of equipment that are no longer used by the client. What is someone goes back into the nursing facility? What happens to all of the setup furniture etc. The consensus of the group is that it should be reused if possible. The CIL's discussed their loaner program that they are operating.

Diane suggested that we leave it at $2000 with room to move up if needed. There are other forms of reimbursement that can be utilized. Each situation will be unique. Should we have an upper limit amount to be considered to keep spending on one case monitored?

Role Matrix Document

This document is intended to help team members see where they fit in and their responsibilities in the MFP process.

Consumer portion was reviewed with the additions that the group provided.

Helen noted that the role of the Ombudsman is to relay information about the program to nursing facilities and consumers as they travel around the state.

Family will be added to the consumer information. Meredith noted that we need to be careful about the amount of abbreviations that are used in this document so individuals do not get confused.

Transitional Coordinator (CIL's)

It would be helpful for the CIL's to contact the nursing facilities to do an in-service for them to meet the CILs, talk about the grant and describe the process. Committee members are in the process of setting this up across the regions of the state. Family councils would be helpful in disseminating information about the grant. Change determines and will be changed to "identify" needs.

Remove 7th bullet.

Change first one to say informed decisions relating to housing, transportation for a successful transition.

Under transitional coordination, put "Ensure an informed decision regarding available transportation and housing .

Move empower resident to the top of that section.

Add discharge planning team to the second to last bullet

We will come back to relocation statement.

Last bullet: change to refer any consumer whose interests conflict with another for independent advocacy.

Nursing Facility Staff

Change last sentence to an independent setting. We need to make sure that they have a "qualified residence."

Encourage the resident **and family** through the relocation process.

Home and Community Based Case Managers

Add providers to 5th bullet.

Add that HCBS case managers will provide ongoing case management

Protection and Advocacy

Adult and Protective services become involved after someone moves from the facility.

A & P are mandated to do protective services who are DD and mental illness.

APS is a service that must be accessed in each region. It can be administered differently by region.

Money Follows the Person Program Grant Manager

Will spell out the NFTC's to Nursing Facility Transition Coordinators

General education needed about mandatory reporting.

Will add reports from Program Manager will be given on a regular basis to MFP committee members.

Jake thanked the group for work done in last 2 days. It has been very important and helpful in the process.

Jake will bring team together in January to review future documents.

January 22nd afternoon and Wednesday morning, the 23rd AM. 1 to 5 on the 22nd and 9 to 11:30 on the 23rd.

Meeting was adjourned at 12 noon.